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RIGHT TO PSYCHIATRIC TREATMENT

# THE RIGHT TO PSYCHIATRIC TREATMENT: A SOCIAL-LEGAL APPROACH TO THE PLIGHT OF THE STATE HOSPITAL PATIENT

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## I. INTRODUCTION

THIS ARTICLE will consider whether a person who is deprived of his freedom by being held in a mental hospital against his will has a right to be freed, even though he might be dangerous to himself or others and even though he has been appropriately committed, if that hospitalization only warehouses him and does not provide meaningful psychiatric treatment.

Occasional voices, sometimes important ones, have described the bankruptcy of the state mental hospital system in terms that would seem to require quick corrective action.<sup>1</sup> Only a few state hospitals have adequate staffs as measured against minimum standards of the American Psychiatric Association (the "APA"), even though those standards themselves represent a compromise between what would really be adequate and what it was thought could be realized.<sup>2</sup>

In recent years, there has been an increasing emphasis on mental health and some state hospitals have upgraded their efforts. Nevertheless, the lot of the average state hospital patient is unacceptable. In *Marable v. Alabama Mental Health Board*,<sup>3</sup> a suit challenging separate and unequal treatment facilities, the court noted that, for the 2,500 patients at an all-black state hospital, the professional medical staff

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1. Solomon, American Psychiatric Association in Relation to American Psychiatry, 115 AM. J. PSYCHIAT. 1 (1958), *quoted in* Address by Morton Birnbaum, Annual Meeting of American Psychiatric Association, May 8, 1967, i (mimeograph) [hereinafter cited as Birnbaum Address]. See Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752 (1969).

2. Only 15 states have more than 50% of the total number of physicians needed to staff the public mental hospitals according to these standards. On the national average nurses are calculated to be only 19.4% adequate, social workers 36.4% and psychologists 65%. Even the least highly trained, the attendants are only 80% adequate. I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. . . . In many of our hospitals about the best that can be done is to give a physical examination and make a mental note once a year, and often there is not enough staff to do this much.

Solomon, *supra* note 1, at 7.

3. 297 F. Supp. 291 (M.D. Ala. 1969).

consisted of one state licensed medical doctor and four unlicensed Cuban refugee medical doctors.<sup>4</sup>

State mental hospitals suffer, perhaps, from more maladies than their inhabitants. Morton Birnbaum, the originator of the concept that committed mental patients have a right to adequate treatment, has pointed out that geographical factors and commitment policies lead to widely varying rates of hospital admission.<sup>5</sup> The ratio of mental hospital inmates to the general population varies from a high of .657 per cent in the District of Columbia and .492 per cent in New York to a low of .102 per cent in New Mexico and .061 per cent in Utah.<sup>6</sup> These striking differences indicate that social factors rather than strictly medical criteria play a significant role in the decision to commit. Although Birnbaum's use of statistics is not rigorously justified since he has not shown that the same needs for hospitalization exist in both the sparsely settled communities and in the densely settled communities, he has effectively illustrated a discriminatory pattern of hospitalization based upon social policy and availability of facilities rather than upon patients' needs.

In spite of the reservations concerning Birnbaum's methodology, this Article accepts the proposition that the state mental health system

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4. The campaign against the use of foreign-born doctors in the state mental hospital system has been spearheaded by F. Lewis Bartlett, M.D., a psychiatrist with the Pennsylvania state hospital system, not on chauvinistic grounds, but because (1) doctors who cannot qualify for state licenses and can get no other jobs are hired by state hospitals; (2) many of these doctors have neither an aptitude nor a liking for psychiatry; and (3) verbal skill is a main requisite for verbal psychotherapy (in the absence of verbal aptitude, therapy often becomes merely a matter of dispensing tranquilizers). One out of every six practicing doctors in the United States received medical training abroad. Most of these employed in hospitals have passed tests indicating they have at least minimum competence in medicine and in English. "There are numerous community hospitals in this country that would have little in the way of resident house staff if it were not for the availability of foreign trainees." Schwartz, *Where'd we be without them?* N.Y. Times, Jan. 9, 1972, § E, at 6, col. 1. According to Bartlett:

Traditionally, most states have had provisions for doctors with restricted licenses to practice in state hospitals, and in some states without provisions, such doctors practiced on the superintendent's license.

In the new period of medical psychiatry, one would expect that this trend would be reversed. But it has not been. Last year, according to the *AMA State Legislative Roundup*, four additional states (Arizona, California, Oklahoma, and Washington) relaxed licensure requirements for state-hospital-staff employment. Dr. Henry A. Davidson, superintendent of Overbrook Essex County (state) Hospital, New Jersey . . . remonstrated recently in the *American Journal of Psychiatry*, "Interestingly, in every other medical activity, a license is required — but for us the rule is often waived. For public mental hospitals, anything goes." . . . [T]o quote Dr. Davidson again: ". . . Thus there accumulates . . . a surplus of physicians who cannot leave because they are unlicensed, or whose physical health or psychotherapeutic skills do not make a private practice an inviting possibility." Bartlett, *Present-day Requirements for State Hospitals Joining the Community*, 276 N.E.J.M. 91 (1967). See note 82 *infra*.

5. Birnbaum Address, *supra* note 1, at 3.

6. *Id.* at 3-4. For a similar argument, using later but similar statistics, see Birnbaum, *supra* note 1, at 768 n.48.

is bankrupt; it reviews the legal attempts to force the state to improve its hospitals; and it sets forth eight social-legal proposals to implement the concept of the right to treatment and to ameliorate the plight of the state mental hospital patient.

Birnbaum developed the concept of the right to treatment during the 1958–59 academic year as a Research Fellow in the Department of Social Relations at Harvard University. His enunciation of the right appeared in a law journal<sup>7</sup> in 1960, but he was not published in a psychiatric journal until 1965.<sup>8</sup> The focal point of his proposition is that, since the mental patient's deprivation of liberty is for *treatment* and does not arise out of any criminal conviction, there is a fifth amendment guarantee against continued institutionalization if adequate treatment is not provided on a continual basis.<sup>9</sup>

Birnbaum is not a Szaszian who denies the reality of mental illness and believes all involuntary patients should be freed;<sup>10</sup> he is content to see patients held against their will if the effort to restore them to a level where they can be released is equivalent to the effort that would be expended by a private hospital.<sup>11</sup> As a spokesman for the rights of the mental patient, he advocates a "treat me or let me go" policy, not because freedom would necessarily be beneficial for the patient, but because the threat of judicially enforced emancipation could supply the political leverage that would force the appropriation of funds and the procurement of psychiatric manpower that would equalize the treatment potential of public and private mental hospitals.<sup>12</sup>

His solution to the problem of disparity is succinct, simple, and elegant. If a patient is hospitalized in accordance with the minimum requirements for accreditation suggested by the APA for *private* mental hospitals, he is presumed to be receiving adequate treatment. However, if minimum standards are not met, as is true in almost all *public* hospitals, the patient is presumed not to be receiving adequate treatment and is released.<sup>13</sup>

Enforcement of the right to treatment would be via a habeas corpus proceeding which would consider only three issues: (1) whether the commitment had been in accordance with state law; (2) whether the patient is sufficiently ill to require continued hospitalization; and

7. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

8. Birnbaum, *Some Comments on "The Right to Treatment,"* 13 ARCHIVES GEN. PSYCHIAT. 34 (1965).

9. *Id.* at 43.

10. For a discussion of this extreme position, see Slovenko, *Civil Commitment in Perspective*, 20 J. PUB. L. 3 (1971).

11. Birnbaum Address, *supra* note 1, at 21.

12. Birnbaum, *supra* note 8, at 40.

13. *Id.*

(3) whether the hospital provides adequate treatment as measured by standards of patient-personnel ratios and other easily applicable objective criteria.<sup>14</sup> The proceeding would specifically ignore the issue of the patient's potential for danger. Significantly, on this issue, Birnbaum presents evidence that mental patients are no more dangerous than others and that the various communities of the United States which have high concentrations of mental patients do not have significantly higher murder, manslaughter, or suicide rates.<sup>15</sup>

## II. THE JUDICIAL DEVELOPMENT OF THE RIGHT TO TREATMENT

The first case to declare that there existed, in addition to society's moral duty, a legal right of the patient to treatment was *Rouse v. Cameron*.<sup>16</sup> Chief Judge Bazelon, the spokesman for the *Rouse* court and the author of a number of decisions which dealt with criminal responsibility and mental state, the most famous of which is the *Durham* decision of 1954,<sup>17</sup> can properly be said to have, "[a]t the very minimum, . . . more than any other jurist . . . brought the dialogue between psychiatry and law into the twentieth century."<sup>18</sup> Serious students of forensic psychiatry, however, have questioned Bazelon's approach. He has dealt with the most sensitive areas of legal psychiatry by "judicial legislation" because of his belief that legislatures — which in the District of Columbia means the Congress of the United States — have not moved fast enough to promote change. Many authorities in the field, however, Birnbaum included, believe that meaningful changes will depend on legislative action.<sup>19</sup>

In 1962, Rouse was arrested for carrying a weapon without a license.<sup>20</sup> His insanity defense was based on a psychiatric report which stated that he was suffering from a passive-aggressive person-

14. Birnbaum Address, *supra* note 1, at 21-22.

15. See Birnbaum, *supra* note 1, at 765. Birnbaum ignores some correlates of admission rates; they are highest in most densely populated areas and lowest in least densely populated areas. Although this may be partly related to the availability of facilities, regional attitudes concerning hospitalization, concentration of individuals living under stressful conditions, and other factors, it may also be related to a decreased potential for harm and self-harm in areas where there is more "living space."

16. 373 F.2d 451 (D.C. Cir. 1966).

17. *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954).

18. Stone, *Psychiatry and the Law*, 1(2) PSYCHIAT. ANN. 18, 23 (1971).

19. Stone raises the question of Bazelon's legal philosophy and refers to "the extent to which in comparison with other jurists he favors judge-made law as opposed to judicial restraint." *Id.* at 23. A jurist dealing with forensic psychiatry questions might be disposed to resort to judge-made law because legislatures find it extremely difficult and time-consuming to debate mental health questions, and many proposed legislative changes either are not sufficiently understood to marshal legislative support or are enacted in a manner that does not implement the intention of the proposed change.

20. 373 F.2d at 452.

ality disorder and that the crime was the product of this mental disease. Such a defense was sufficient to acquit by reason of insanity under the *Durham* rule but not under the *M'Naghten* rules which *Durham* has superseded. Rouse, therefore, was committed to St. Elizabeth's Hospital, where, still a patient four years later, he petitioned for release.

Birnbaum did not consider the *Rouse* case an appropriate vehicle for the actualization of his new legal concept.<sup>21</sup> Rouse was not the typical state hospital patient, neglected on a back ward. Instead, he was a patient first diagnosed as passive-aggressive and thereafter as a sociopath who was not in the hospital for a primarily psychiatric purpose; his hospitalization was a detention in lieu of imprisonment. To further complicate matters, Rouse was a patient for whom there was no recognized treatment. In contrast to a more hopeful attitude towards neurotic and even psychotic patients, many psychiatrists feel sociopathy — a somewhat vague concept often attacked as a "wastebasket" category — will not usually be altered by hospital treatment. Since the thrust of Birnbaum's theory concerns the adequacy of treatment, his position falters when attempting to mandate proper treatment for a potentially untreatable sociopath.<sup>22</sup>

In considering the facts of the *Rouse* case, few fair-minded people would have wanted to deny Rouse his freedom. The record showed his plea of not guilty by reason of insanity had been made when he was eighteen, and had been made over his objections by counsel, counsel not of his choice.<sup>23</sup> He had been held for a period four times longer than the maximum sentence for which he could have been convicted had he not asserted the insanity defense. It is submitted that some other reason for ending his hospitalization would have been preferable to asserting the denial of his right to treatment which involved the additional issue of the proper treatment for this most difficult kind of patient.

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21. Birnbaum Address, *supra* note 1, at 46.

22. A recent book on sociopathy, sometimes called psychopathy, gives conclusions which seem representative of much of psychological and psychiatric opinion; that is, traditional therapy is not effective in changing the behavior of psychopaths. One possibly hopeful approach is the therapeutic community which is designed to help the sociopath relate to others in a structured social environment. R. HARE, *PSYCHOPATHY: THEORY AND RESEARCH* (1970).

From the point of view of legal process, for at least two further reasons, the case might be considered inappropriate for the pronouncement that it made. First, Judge Bazelon's tortuous construction of the statute, D.C. CODE ANN. § 21-562 (1967), extends to the patient involved in the criminal process the right to the care which the legislature had restricted, in the view of some commentators, to the civil patient. 373 F.2d at 454 n.18a. See Comment, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 YALE L.J. 87, 90 n.11 (1967). Secondly, the treatment matter was not, in fact, in issue before the court, since Rouse wanted release, not care. 373 F.2d at 462 (Danaher, J., dissenting).

23. *Rouse v. Cameron*, 387 F.2d 241, 242 (D.C. Cir. 1967).

In his writings about the right to treatment, Birnbaum emphasizes that courts should not interfere in the appropriateness of the treatment offered an individual patient; instead, he suggests broad objective standards of adequacy of care based primarily upon the number of personnel and the frequency of consultations.<sup>24</sup> Such standards would serve to keep the lid on a potential Pandora's box:

If a person were to bring a habeas corpus proceeding and allege inadequate care and treatment, all the hospital director would have to do is to submit *pro forma* evidence setting forth the number of inmates, the number and type of personnel, the adequacy of the physical facilities and, probably, the number of consultations with a physician that the inmate had within the standard maximum period of time. After a statistical showing that the institution meets the minimum standards of the American Psychiatric Association that would be the end of the litigation as far as the usual case involving the right to adequate care and treatment is involved . . . .<sup>25</sup>

Although Birnbaum paid tribute to the *Rouse* decision as a landmark because of its discussion of the right to treatment, he also criticized it for the lack of any practicable remedy to enforce the newly enunciated right.<sup>26</sup> *Rouse* only held that, in the absence of adequate treatment, the petitioner *may* be released but such release is not mandated. Additionally, *Rouse* has been criticized for going beyond a mere demand that the institution have adequate staff and physical facilities by requiring that the institution show "the suitability and adequacy of . . . the . . . therapy . . . for *this* petitioner."<sup>27</sup> In *Rouse*, this requirement resulted in 500 pages of testimony from the hospital director and seven mental health personnel — psychiatrists, psychologists, and ward attendants.<sup>28</sup>

*Rouse* also raises the issue, implicit in every case in which a court considers the suitability of an individual's treatment, that merely being in a hospital is a form of treatment in itself. Milieu therapy suggests a treatment not confined to the limits of the doctor-patient relation-

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24. Birnbaum Address, *supra* note 1, at 21-22.

25. *Id.* at 29. More recently Birnbaum has spelled out a more complete list of desirable institution-wide standards: (1) institution accreditation by the Joint Commission on Accreditation of Hospitals; (2) qualification for Medicare and Medicaid funds through Social Security Administration certification; (3) physical standards that meet minimum standards set by the APA; (4) personnel-patient ratios that meet the former standards for private hospitals set by the APA; (5) required state licensing for all professional hospital personnel; (6) regularly recorded progress notes reflecting patient-physician consultation; and (7) establishment of halfway houses and intermediate facilities. Birnbaum, *Some Remarks on the "Right to Treatment,"* 23 ALA. L.R. 623, 628-35 (1971).

26. Birnbaum Address, *supra* note 1, at 43.

27. 373 F.2d at 459.

28. Birnbaum Address, *supra* note 1, at 46.

ship, but rather resulting from all interactions of hospital and patient throughout the day.<sup>29</sup> The milieu can be designed to maximize the patient's opportunity to recover. The concept has been debased by apologists for inadequately staffed hospitals who have maintained, in their own defense, that the milieu *is* the treatment; that, even in the absence of other treatment modalities, the hospital may safeguard, reassure, or contain the patient and thus help in his recovery. An extreme example of the psychiatric view that incarcerations and restraint are in themselves a form of treatment is found in *In re Maddox*,<sup>30</sup> where four psychiatrists testified that incarceration in *prison* was the proper psychiatric treatment for a patient who was committed pursuant to a sexual psychopath statute.<sup>31</sup> In *Maddox*, the patient would not admit he had committed the crime and the psychiatrists, therefore, testified that he would not fit into the therapy program in the state mental hospital. It has been suggested that the courts should be skeptical of institutions that provide the same regimen for all patients under the rubric of milieu therapy.<sup>32</sup> However, the concept of milieu therapy, which can be argued as a justification for any commitment, does complicate the task of a court seeking to define adequate psychiatric treatment.

Birnbaum was particularly disappointed that Judge Bazelon did not base the right to treatment upon the fifth amendment guarantee that no person is to be deprived of liberty without due process of law. Instead, Bazelon based his decision upon an analysis of the broad language of the 1964 revision of the mental health statutes of the District of Columbia: "A person hospitalized in a public hospital shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."<sup>33</sup> This was a unique interpretation; similar wording in other jurisdictions had never been interpreted to include the right to certain standards of treatment. It should be noted that in spite of Bazelon's uncompromising declaration of a right to treatment, Rouse was not able to secure his freedom.<sup>34</sup>

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29. M. JONES, *SOCIAL PSYCHIATRY* (1952).

30. 351 Mich. 358, 88 N.W.2d 470 (1958).

31. Cf. MICH. COMP. LAWS §§ 28.967(1) *et seq.* (1951).

32. Helpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782 (1969).

33. D.C. CODE ANN. § 21-562 (1967).

34. Judge Bazelon remanded the case to the district court in order that a determination could be made as to the adequacy of the treatment being provided Rouse. 373 F.2d at 451. The district court found that Rouse had, in fact, been provided with adequate treatment. *Rouse v. Cameron*, Habeas Corpus No. 287-65 (D.D.C., filed Jan. 17, 1967). Helpern, *supra* note 32, at 786, notes the further course of the case: the discovery of defects in the original commitment, an issue unrelated to the adequacy question; the final court order releasing Rouse because of the defect in his commitment and dismissing the appeal from the treatment hearing as moot. *Rouse v. Cameron*, 387 F.2d 241 (D.C. Cir. 1967).



*Rouse* resembles another Bazelon decision, *Lake v. Cameron*,<sup>35</sup> which also set forth an important legal precedent but which, in the final result, did not benefit the interested party in the manner anticipated. In *Lake*, the petitioner, a senile and sometimes confused patient, had been committed to St. Elizabeth's because adequate nursing home facilities were unavailable. Although the court found this to be an improper use of the commitment process (no sufficient reason for depriving Mrs. Lake of her freedom had been established), in subsequent proceedings the court allowed the hospital to retain Mrs. Lake on a showing by authorities that no alternative facilities were available in the District of Columbia.<sup>36</sup>

The criteria for proper hospitalization in *Rouse* and *Lake* require consideration of individual cases by the courts. It is ironic, but the process apparently involves the court first registering its fear that a patient is being improperly held, and then throwing the burden onto the legislature to provide better treatment alternatives; but, if the legislature does not act to remedy the situation by providing more therapy or better treatment facilities, the petitioner may remain in the institution.<sup>37</sup>

Massachusetts was the second jurisdiction to enunciate the right to treatment, even in the absence of a specific statute requiring care. In *Nason v. Superintendent of Bridgewater State Hospital*,<sup>38</sup> the patient was confined in a maximum security hospital, that curious hybrid (the field of legal psychiatry is a natural habitat for hybrids) between a maximum security prison and a mental hospital. The *Nason* court "perceive[d] no denial to Nason of any constitutional right merely because of his confinement in a maximum security institution, if he is there afforded adequate treatment."<sup>39</sup> Although the record indicated Nason had received little or no treatment, the court

35. 364 F.2d 657 (D.C. Cir.), *cert. denied*, 382 U.S. 863 (1966).

36. *Lake v. Cameron*, 267 F. Supp. 155 (D.D.C. 1967).

37. Two and a half years after *Rouse*, the level of treatment of the mentally ill did not seem to have improved significantly.

One would hardly expect to see overnight results after the enunciation of so novel a principle as the judicially cognizable right to treatment. Yet, the "deliberate speed" in the desegregation of public schools following *Brown v. Board of Educ.* [349 U.S. 301 (1955)] has probably been faster than the rate of change that has followed the *Rouse* decision. The aftermath of *Rouse* has again demonstrated the limited impact of judicial decisions.

Helpert, *supra* note 32, at 783-85.

38. 353 Mass. 604, 233 N.E.2d 908 (1968). In a related case, *Nason v. Commissioner of Mental Health*, 351 Mass. 94, 97 n.4, 217 N.E.2d 733, 736 n.4 (1966), the defendant conceded that the language of Mass. Gen. Laws, ch. 123, §§ 100 & 105 (1969), could be construed to entitle plaintiff to "care, observation, treatment." The question can be raised whether *Nason v. Superintendent* was decided on constitutional or statutory grounds.

39. 353 Mass. at 612, 233 N.E.2d at 913.

took judicial notice of state efforts to improve the hospital<sup>40</sup> and would not assume that efforts to provide fully adequate treatment would not be completed.<sup>41</sup> The court allowed the hospital an opportunity to institute any program of treatment that might be suggested by competent doctors "in their best judgment within the limits of permissible medical practice."<sup>42</sup> If the program was not instituted, the petitioner could bring the matter before the county court which retained jurisdiction.

Both *Nason* and *Rouse* cited precedents predating the enunciation of the right to treatment doctrine. Similarly, both relied on cases in which sexually dangerous persons (defined by sexual psychopath laws and by psychiatric practice as psychiatric medical cases, but sent to institutions where they were in fact dealt with as social deviants) were committed for indefinite periods of time in lieu of a prison sentence. These patients did not receive sufficient remedial care to escape the constitutional requirements of due process.<sup>43</sup>

Two additional District of Columbia Circuit Court decisions dealt with the appropriateness of the treatment — or, more properly, of the kind of confinement — accorded to patients who had originally entered the state hospital after committing acts which ordinarily would be considered criminal. In *Tribby v. Cameron*<sup>44</sup> and *Covington v. Cameron*,<sup>45</sup>

40. *Id.* at 613, 233 N.E.2d at 914.

41. *Id.*

42. *Id.*

43. *Commonwealth v. Hogan*, 341 Mass. 372, 170 N.E.2d 327 (1960); *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 83 (1959). The consequences of labeling a person as either a medical problem or a social deviant and the conceptual distinctions between these categories have become obscured. Enforced psychiatric treatment for drug and alcohol addiction and for sexual deviancy has been cited as an example. Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior*, 53 MENTAL HYGIENE 21 (1969).

Birnbaum's theory differentiates the deprivation of liberty of committed mental patients, who are civilly committed and deprived of their liberty solely because of mental illness requiring treatment, and the deprivation of liberty of lawbreakers who (a) may be psychotic or become psychotic and require psychiatric treatment, or (b) may be sentenced for non-therapeutic purposes — to be taught a lesson, to provide an example, to be isolated from society. The lawbreaker, unlike the civilly committed patient, is not deprived of liberty primarily for treatment purposes. Unfortunately, both *Rouse* and *Nason*, as well as other decisions such as *Tribby* and *Covington* (see text accompanying notes 44 & 45 *infra*), dealt with the lawbreaker held in the hospital; not until *Wyatt* (see note 60 *infra*) did the courts begin to wrestle with Birnbaum's concepts. To further complicate the matter, Hutt and others have pushed for a new classification of alcohol and drug related offenses as symptoms of a disease rather than as transgressions of law, and thereby entitled to a therapeutic rather than a punitive or correctional approach. The inclusion of such reclassificatory schemes with Birnbaum's ideas have made it much more difficult for jurists to grasp the neatness and the simplicity of the Birnbaum concept. See Hutt & Merrill, *Criminal Responsibility and the Right to Treatment for Intoxication and Alcoholism*, 57 GEO. L.J. 835 (1969), which focuses not on state mental hospital patients, but on an entirely different class of patients, habitual drunkards and chronic alcoholics — persons who have not traditionally been civilly committed to state mental hospitals but have been dealt with by the criminal process.

44. 379 F.2d 104 (D.C. Cir. 1967).

45. 419 F.2d 617 (D.C. Cir. 1969).

the court refined the review procedures employed by courts in regard to therapeutic programs. *Tribby* declared that it was not the function of the court to substitute its own judgment for the judgment of hospital administrators, but the courts should only insure that administrators have made permissible decisions — those which demonstrably take account of the relevant information available to the decision maker.<sup>46</sup> In *Covington*, Judge Bazelon refined the limited judicial review as follows: the court must assure itself that the decision makers "have (1) reached a reasoned and not unreasonable decision, (2) by employing the proper criteria, and (3) without overlooking anything of substantial relevance. . . . More than this the courts do not pretend to do, and probably are not competent to do. To do less would abandon the interests affected to the absolute power of administrative officials."<sup>47</sup>

It is submitted that, even with such limitations on review, the courts could easily be overburdened by the type of scrutiny Bazelon desired. The feasibility of review of individual treatment decisions was considered in *Dixon v. Commonwealth*.<sup>48</sup> The district court was asked to declare unconstitutional a form of commitment procedure used in Pennsylvania<sup>49</sup> on various grounds, including the unavailability of therapy. Although the same court in a subsequent related case did find the commitment procedure unconstitutional on other grounds,<sup>50</sup> the *Dixon* court was not willing to delve into the treatment question:

If . . . we were to hold [the challenged section] unconstitutional, either on its face or in its application to the plaintiffs and to others of their class, we quite possibly would have to supervise the therapy of several hundred persons. Could we compel the staffs of . . . Pennsylvania mental institutions to . . . determine the status of each individual? These questions, since several hundred individuals are involved, could present a lengthy, if not almost interminable, process and might perhaps be unmanageable.<sup>51</sup>

At the other end of the spectrum from the *Dixon* court's refusal to probe the treatment situation is *McCray v. Maryland*,<sup>52</sup> in which the Circuit Court for Montgomery County, Maryland, promulgated 35 pages of rules and regulations for the Patuxent Institution, Maryland's unique penal-therapeutic institution where criminals who have been diagnosed and adjudicated to be defective delinquents can be sent for

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46. 379 F.2d at 105.

47. 419 F.2d at 621.

48. 313 F. Supp. 653 (M.D. Pa. 1970).

49. PA. STAT. tit. 50, § 4404 (1966).

50. *Dixon v. Commonwealth*, 325 F. Supp. 966 (M.D. Pa. 1971).

51. 313 F. Supp. at 655.

52. No. 4363 (Cir. Ct. Montg. Co., Md., filed Nov. 11, 1971).

rehabilitation for as little as a day or for as long as life under a civil commitment procedure.<sup>53</sup> The rules promulgated by the court specified the personal possessions the inmate may have in his cell (not more than three undershirts and three undershorts), the edibles he may possess (including three rolls of Tums), and hundreds of other details of institutional life. Additionally, Patuxent staff psychiatrists testified that penal incarceration could be used as a form of psychiatric treatment.<sup>54</sup> The court found that two sections of the institution used for solitary and disciplinary confinement, referred to by the staff as "negative reinforcers," were not for treatment but were instead a "prison within a prison"<sup>55</sup> and were only to be used with appropriate procedural and regulatory safeguards.<sup>56</sup> The detailed opinion extended to a review of the training of the custodial staff and focused on the court's finding that the rehabilitation program's philosophy of total rehabilitation of the person was not being met by the institution's use of group therapy, limited vocational training, and "negative reinforcers." The court ordered that "[t]reatment in the Patuxent Institution should be immediately accelerated without regard to strict budgetary limitations imposed by the state. The institution must perform its responsibilities to the patients to comply with constitutional guarantees."<sup>57</sup>

The aforementioned cases were all concerned with the patient who was forced into the mental health system because of a criminal charge or conviction; the question of detention without treatment of the typical mental hospital patient who is not a law violator and is hospitalized solely for mental illness remained unconsidered until *Wyatt v. Stickney*,<sup>58</sup> a decision concerning patients at Bryce Hospital in Alabama.

*Wyatt* focused upon the patient population that concerned Birnbaum. The court went further than *Rouse*, *Covington*, *Tribby*, and *Nason* by ordering the state hospital and the Commissioner of Mental Health for Alabama to institute an effective treatment plan; in addition, the court specifically retained jurisdiction over the case. "Indeed, the court seemed prepared to commit Bryce Hospital to judicial 'receivership' if necessary to ensure proper treatment for the patients there confined."<sup>59</sup>

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53. MD. ANN. CODE art. 31B, § 9 (1957).

54. *McCray v. Maryland*, No. 4363, at 13 (Cir. Ct. Montg. Co., Md., filed Nov. 11, 1971). See text accompanying note 30 *supra*.

55. *McCray v. Maryland*, No. 4363, at 13 (Cir. Ct. Montg. Co., Md., filed Nov. 11, 1971).

56. *Id.* at 13-15.

57. *Id.* at 41.

58. 325 F. Supp. 781 (M.D. Ala. 1971).

59. 23 ALA. L. REV. 642, 652 (1971). See Grad, *Upgrading Health Facilities: Medical Receivership as an Alternative to License Revocation*, 42 COLO. L. REV. 419 (1971).

The problem of implementing the mandate of the *Wyatt* decision still remains. The court stated that it would give the hospital six months, from the date of the court's order<sup>60</sup> to implement fully a treatment program that will give each of the treatable patients therein a realistic opportunity to be cured or to improve his mental condition. The court stated that if the program has not been fully implemented it would then appoint a panel of mental health experts to determine the objective and subjective hospital standards that would be required.<sup>61</sup> It has been proposed, using the analogy of school desegregation rulings, that the Alabama Mental Health Board, a party to the suit, be ordered to use its resources to upgrade Bryce under the penalty of contempt of court for failure to do so; if funds are not adequate, the Governor of Alabama, also a party to the suit, could be ordered to allocate extra funds for Bryce, and eventually a separate suit to compel the state legislature to appropriate more money might be needed.<sup>62</sup>

The legal concept of a constitutional right to treatment rests almost entirely on Judge Johnson's decision in *Wyatt*. Johnson, a federal district judge, indicated his determination to implement his earlier decision in a December 10, 1971 order:

There seems to be a consensus of opinion among the experts that the treatment program at Bryce Hospital continues to be wholly inadequate. . . .

The primary and fundamental question remaining in this case, therefore, is not whether the defendants have promulgated and implemented a program that meets minimum medical and constitutional standards, but what procedure this Court should now pursue to ensure that this be done. Although the goals defendants have set are rather vague, the defendants [Commissioner of Mental Health and Superintendent of Bryce Hospital] have to this point generally demonstrated good faith and a desire to attain minimum medical and constitutional standards in the three primary

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60. On September 23, 1971, defendants filed their final report, from which the court concluded that they had failed to promulgate and implement a treatment program satisfying minimum medical and constitutional requisites. *Wyatt v. Stickney*, 334 F. Supp. 1341 (M.D. Ala. 1971). On April 13, 1972, the court enjoined the defendants from failing to implement fully and with dispatch the standards set forth in an appendix to the order. It appointed human rights committees for Bryce and Searcy Hospitals to review research and rehabilitation programs and to advise and assist patients who allege that their legal rights have been infringed (the fourteen members of the two committees include no psychiatrists — only one member is a physician, a general surgeon). The court required a further report in another six months and specifically retained jurisdiction of the case. For a discussion of the manpower requirements of the order, which requires a total of 207.5 personnel, including two psychiatrists and four other physicians, for every 250 patients, see Robitscher, *Courts, State Hospitals, and the Right to Treatment*, 129 AM. J. PSYCHIAT. 298, 302 (1972).

61. 325 F. Supp. at 785.

62. 23 ALA. L. REV. 642, 655 (1971).

mental institutions now operated by the State of Alabama. Consequently *this Court will again defer turning over the operation of these institutions to a panel of masters.*

Nonetheless, minimum medical and constitutional standards for the operation of these institutions must be formulated. Defendants have been given an opportunity to perform this task and have failed. . . . This Court has concluded that . . . the matter . . . be set again for formal hearing . . . for the purpose of allowing the parties and the amici the opportunity to present proposed standards that meet medical and constitutional requirements for the operation of the three mental institutions herein concerned and to present evidence by experts in support thereof. From this evidence *this Court will establish standards and in due course order their implementation.*<sup>63</sup>

The court stated three fundamental conditions for adequate and effective treatment programs in public mental institutions: (1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to administer adequate treatment; and (3) individualized treatment plans.<sup>64</sup>

### III. THE LEGISLATURE'S ROLE IN DEVELOPING A RIGHT TO TREATMENT

Birnbaum does not fully agree with the *Wyatt* approach which relies on judicial development. He asserts a constitutional right to adequate treatment or release before the courts, but also seeks action from legislatures to establish this right. It is his contention that:

[T]he state legislature rather than the judiciary, seems the proper instrumentality to take the lead in establishing and enforcing a right to adequate treatment. Only the legislature has means to set up a comprehensive scheme and to coordinate it with necessary legislative appropriations; the judiciary is limited to a case-by-case development.<sup>65</sup>

One state where a serious effort has been made to seek a legislative enactment of the right to treatment is Pennsylvania. There, through the efforts of Birnbaum and Pennsylvanians active in hospital reform, a bill was introduced into the state legislature in 1968 and reintroduced in successive years which would provide a minimum level of care for all patients as a matter of right.<sup>66</sup>

63. 334 F. Supp. at 1344 (emphasis added).

64. *Id.* at 1343.

65. Birnbaum, *supra* note 1, at 765.

66. Right to Treatment Law, S.B. 1274, Pa. Gen. Assembly, 1968 Sess. (H.B. 2118 was identical to the Senate bill), reprinted in Helpert, *supra* note 32, at 811.

The proposed statute included a number of provisions that did not seem novel — minimal requirements based on common sense — but are so far in excess of present state hospital practice that they are in fact revolutionary. The statute required: (1) the establishment of a State Mental Treatment Standards Committee charged with setting minimum standards, such as ratios of personnel to patients and a minimum number of consultations and physical examinations within stated time periods<sup>67</sup> (in order to avoid the danger of undue interference with hospital administration, this committee is barred from establishing methods or quality of treatment);<sup>68</sup> (2) all professional personnel employed in a state mental hospital be eligible for licensure within the state;<sup>69</sup> (3) state hospitals maintain complete and accurate records of treatment for each patient in order to ascertain whether the treatment offered is within minimum standards;<sup>70</sup> (4) the establishment of a Patient Treatment Review Board to investigate, hear, and decide questions of adequate treatment;<sup>71</sup> and (5) a program by which patients in inadequately staffed public mental hospitals can have non-staff physician care at public expense.<sup>72</sup>

Birnbaum, although a draftsman of this legislation, sees it as a compromise. He is in favor of the legislative approach to the problem, but he would prefer a less complicated law under which a person inadequately treated would simply be allowed to obtain his release.

#### IV. PSYCHIATRY'S RESPONSE TO THE RIGHT TO TREATMENT

What reception has the concept of the right to treatment received in psychiatric circles? Lawyers were interested in the concept from its inception, but Birnbaum, who is not a psychiatrist, had to wait a number of years to obtain a hearing in the psychiatric journals and at psychiatric meetings. When psychiatry did respond, the reception was mixed. The concept got a strong boost in 1967 from the Director of the National Institute of Mental Health, the most influential figure in psychiatry, who stated that adequacy of treatment was an area in which the courts should be involved, even though the possible danger in judicial definitions of adequate treatment or mental health was apparent:

It is society's responsibility to provide for adequate treatment.  
It is the psychiatrist's responsibility to treat adequately in the light

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67. *Id.* § 3.

68. *Id.* § 4(d).

69. *Id.* § 4(c). See note 4 *supra*.

70. *Id.* § 4(h).

71. *Id.* § 6.

72. *Id.* § 8(g).

of present knowledge. It is the court's responsibility, under due process of law, to protect the liberties of persons involuntarily detained, and to rule on practice for the individual case at hand.<sup>73</sup>

However, the concept has not been supported by many psychiatrists, and the APA has opposed it. Following the first *Rouse* decision, the Council of the APA in February 1967 approved a position statement on the question of the adequacy of treatment.<sup>74</sup> While acknowledging that staff shortages exist in state hospitals, the position statement declared that the proposal for release of patients when "ideal staff ratios cannot be maintained to provide adequate treatment . . . [is] tantamount to an oversimplified gospel of perfection. Clearly, in the perspective of the over-all mental health manpower shortage in our country, one must settle for something less until personnel shortages can be overcome."<sup>75</sup> The position statement preferred the vague standard of the Model Draft Act: "every patient is entitled to treatment to the extent that facilities and personnel are available."<sup>76</sup> In 1969 the APA dealt the Birnbaum plan a second blow by discontinuing its formulation of minimal patient-staff ratios for private mental hospitals.<sup>77</sup>

#### V. THE SPECIAL PROBLEMS OF THE STATE MENTAL HOSPITAL

Will the right to treatment solve the problem of the state mental hospital? It can focus attention on the problem and give it more publicity than would be available by any other means and thereby hasten change. But experience in other fields of social-legal psychiatry indicates that legal cases do not in themselves produce meaningful change. The problem of the criminal responsibility of the mentally disabled has become more, not less, difficult as a result of *Durham*.<sup>78</sup> *Lake v. Cameron*<sup>79</sup> has not produced alternatives to state hospitalization for the confused geriatric patient. The *Kent*<sup>80</sup> and *Gault*<sup>81</sup> cases have not produced great reforms in the juvenile justice system or in the institutions in which delinquents are held.

The right to treatment, in the interests of simplicity and of ease of judicial review, depends on quantitative standards to demonstrate

73. Yolles, *The Right to Treatment*, 28 PSYCHIAT. DIG. 7, 13 (Oct. 1967).

74. American Psychiatric Association, *Official Actions*, 123 AM. J. PSYCHIAT. 1458 (1967).

75. *Id.* at 1460.

76. *Id.*

77. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES 29 (1969).

78. See note 17 and accompanying text *supra*.

79. See notes 35 & 36 and accompanying text *supra*.

80. *Kent v. United States*, 383 U.S. 541 (1966).

81. *In re Gault*, 387 U.S. 1 (1967).



adequate treatment. However, the state mental hospital system has so many shortcomings that even increasing the same kind of services would not necessarily make treatment adequate. There would still be wide disparities between the state hospital system and the kind of care patients receive as inpatients in private hospitals and as outpatients in the offices of private practitioners.

Real differences exist between state hospital personnel and the personnel of the private sector of psychiatry. In order to fill quotas of physicians, most states do not require licensure for state mental hospital physicians; the result, therefore, is that the state hospital physician is frequently foreign-born, speaking English as a second language.<sup>82</sup> Furthermore, since state hospital psychiatric practice generally does not include the opportunity for verbal therapy on a one-to-one basis, the state hospitals usually attract and hold physicians who are comfortable dispensing drugs — tranquilizers or anti-depressants — or who enjoy administration more than individual therapy. This is in contrast to the model of private psychiatric practice which continues to be verbal psychological investigation. Moreover, even where hospitals do employ group therapy methods, they often rely on untrained personnel as group leaders.

State hospitals have been further hampered by their geographical inaccessibility, a product of society's desire to push the problems of the mentally ill out of view. The state hospital physician who wants to follow a patient and ease his transition back into the community is not in a position to offer a continuing relationship to the patient after discharge. The main problems of the state hospitals that President Kennedy's Commission found in 1961 — their geographical isolation from the community, their emphasis on inpatient rather than outpatient care, their size, and their impersonality — will remain even if patient-personnel ratios are improved.<sup>83</sup>

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82. See Bartlett, *supra* note 4, at 93.

The type of young man now admitted to the medical schools of the United States (and of Canada and the United Kingdom) is clearly not interested in performing the rather routine types of work now carried out by unsponsored FMG's [foreign medical graduates] from Asia and Latin America. They do not like working in mental institutions and in nonteaching hospitals and in rural areas. If this sort of work were the carrot used to motivate young men of scientific bent to undertake the rigors of medical school, hospital training and military service, medical schools might find a shortage of applicants.

*Id.* See also Shurcliff, Book Review, 282 N.E.J.M. 458 (1970).

83. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH (1961). One commentator criticized the state hospital system on an entirely different ground — not that insufficient treatment is provided but that no amount of treatment would help many chronic patients. He recommended emphasis on short-term hospitalization rather than on providing more inpatient services. Twerski, *Treating the Untreatable — A Critique of the Proposed Pennsylvania Right to Treatment Law*, 9 DUQUESNE L. REV. 220 (1971). For consideration of many aspects

Modern psychiatry has five main components: private office practice; private inpatient services; services offered without consideration as to ability to pay through community mental health/mental retardation centers; university and teaching-hospital programs stressing research and psychiatric education for residents; and the state hospital system. The first four of these components interact with each other. Private practitioners contribute time to teaching-hospitals and are employed in part-time jobs in community mental health centers affiliated with university departments of psychiatry. Teaching-hospitals and university psychiatry departments provide model care for some inpatients.

Only the state hospital is isolated. It is isolated geographically because mental hospitals have traditionally tried to insulate society from the hospital population, but it is isolated more thoroughly by the lack of interaction with the private sector, the university sector, and those organizations like the APA and the Group for the Advancement of Psychiatry ("GAP") which represent the more genteel kind of psychiatric practice.

#### VI. PROPOSALS TO IMPLEMENT THE RIGHT TO TREATMENT

If the doctrine of a right to treatment, either on statutory or constitutional grounds, continues to make headway — and even if it does not — there are a number of other important approaches to the plight of the state hospital patient that are less dependent on court action. The remainder of this Article suggests an eight-point program of social-legal approaches to the problem of offering adequate treatment to patients in state mental hospitals.

(1) *Universities and training-hospitals must become involved in the problem of the state hospital's neglected patients.*

University-affiliated and private hospital-affiliated training programs have, until recent years, been interested only in affluent (or insurance rich) patients and in those indigent patients who made good teaching cases. A new development has been their sponsorship of community mental health and mental retardation programs, and through these, they have for the first time provided services across-the-board for all social classes. But this democratization of psychiatry applies only to outpatient community mental health centers convenient to a university or private hospital; the state hospital system continues to be outside

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of Birnbaum's thought, see *THE RIGHT TO TREATMENT* (D. Burris ed. 1969); *THE MENTALLY ILL AND THE RIGHT TO TREATMENT* (G. Morris ed. 1970).

the scope of psychiatry's elite private sector. Further, the system is self-perpetuating. Desirable residents who have their choice of residencies are trained at university hospitals where there is emphasis on research and on training for private practice but where there is no training for public institutional work; less desirable residents, especially the foreign-born who cannot meet state licensure requirements, have no alternatives to the state hospital system. Total institutions — state hospitals, homes for the retarded, juvenile rehabilitation centers — have been of interest to sociologists<sup>84</sup> and even to historians,<sup>85</sup> but they have not been sufficiently used as a placement opportunity for training under university sponsorship for medical students, psychiatric residents, or psychology, sociology, and social work degree candidates.

The advantages of university interest are two-fold: a source of young "bodies" — interns, residents, medical students, and degree candidates who in receiving training also provide services — and a source of senior personnel supervising the training program. The resulting improved intellectual atmosphere makes the institution a desirable place to work, yet these advantages are denied to the state hospital system under its present alienation from the mainstream of psychiatry. The self-perpetuating aspects of present methods of personnel selection ensure an ever-deepening chasm.

University-affiliated programs can provide help in other areas besides therapy. The decision to commit, the decision to hold a subject in a state hospital because he is considered incompetent to stand trial, and the decision to recommend treatment for addiction in lieu of a court sentence, are within the bailiwick of hospital personnel; as a result, they need sociological and legal information about consequences of possible decisions if they are to act intelligently. The involvement of university-affiliated personnel has already been elicited in one model program which called for cooperation between five disciplines — psychiatry, psychology, sociology, social work, and law — and which formulated a dual teaching program directed to (a) university medical students and residents and (b) court personnel engaged in the study of the state hospital system.<sup>86</sup> In the university setting, commitability, sexual psychopathy, and defective delinquency were discussed. In the state hospital setting, group therapy was undertaken with hospital inpatients and outpatients with criminal convictions. The total program provided services and teaching in both the university and state hospital

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84. E. GOFFMAN, *ASYLUMS* (1961).

85. D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* (1971).

86. Robitscher, *Three Forensic Psychiatry Programs in the Greater Philadelphia Area*, 2(1) AM. ACAD. PSYCHIAT. & LAW NEWSLETTER 1 (1970).

settings, gave the personnel of each the chance to know and learn from the other, and also gave law students a chance to see the inside of the state hospital system. Other suggested proposals for similar model programs which demonstrate a beneficial interrelationship between university and community are: (1) group therapy for pre-trial "probationers" which would provide the courts with an alternative to imprisonment and offer psychiatric residents and law students a supervised opportunity to work with offenders; and (2) a service program for third-year law students in a state mental hospital to assist patients in the disposition of their legal problems, such as insurance and social security benefits, mortgage payments, and domestic relations and child support.

The intellectual is rewarded by special privileges, in return for which it is his special task to criticize society and develop new approaches to its problems. The intellectual side of psychiatry — its university and private hospital component — must now fulfill these functions for state hospital patients.

*(2) The system of public hospitals and private hospitals will have to be merged into a single system.*

As valuable as the interrelationship of university and state hospital through a common teaching program may prove to be, the inequity of a dual system of medical care will dictate merger. Responsible action by the university to improve state hospital services is only the first step toward such a merger.

The system which provided for a disparate kind of care for private, as opposed to ward, patients has disappeared from general hospitals under the onslaught of health insurance, Medicare, and Medicaid. Psychiatry, where these benefits are limited,<sup>87</sup> remains the only branch of medicine that unblushingly maintains the dual approach — \$7 a day for care of public patients, \$100 a day for care of private patients.

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87. At the present time we have a diversity of health systems that confuse the consumer and make continuity of care almost a bravura achievement. In theory the mental patient has a number of treatment gates through which he may enter — traditional private office practice, group practice in some of our larger cities, the state mental hospital, 2,000 local mental health clinics, community mental health centers, Office of Economic Opportunity centers, Partnership for Health neighborhood centers. . . . But in actual practice, the nagging worry about inability to pay — or the refusal to take charity medicine — severely circumscribes these options.

[U]nder Medicaid, coverage of mental illness depends upon what a particular state government chooses to allocate; the poorer states, which need mental health services the most, are doing the least satisfactory job. A conglomeration of varying formulas, rigid rules for eligibility, and other clumsy yardsticks perpetuate unjustifiable distinctions between rich and poor, between those who have political clout and those who have none, and between various sections of the country.

Gorman, *National Health Insurance: An Idea Whose Time Has Come*, 126 AM. J. PSYCHIAT. 709-10 (1969).

The duality of the mental hospital system has attracted judicial recognition. In a California case alleging improper release of a patient who later murdered his mother, the court held that public mental hospitals do not have to meet the same standards of care as private hospitals. The court noted that public hospitals must take all patients committed to them, causing more and greater problems of supervision and treatment (due to inadequate staff and excessive patient loads) than encountered in private mental hospitals.<sup>88</sup> It is submitted that there is no greater justification for economic segregation than for other forms of compulsory segregation and discrimination. Just as separate and unequal facilities based on racial factors have been seen to violate constitutional safeguards, at some point separate and unequal psychiatric facilities based on ability to pay will also be seen to violate the constitutional right to treatment. Judge Bazelon hinted at this approach in *Lake*,<sup>89</sup> where he admitted that the court's directive to locate a better facility than St. Elizabeth's for Mrs. Lake might be unavailing.<sup>90</sup> He questioned "whether so complete a deprivation of appellant's liberty basically because of her poverty could be reconciled with due process of law and the equal protection of the laws."<sup>91</sup>

(3) *There must be federal participation in upgrading the state hospital system.*

The policy of non-involvement on the part of the federal government was demonstrated in the testimony of Attorney General Robert Kennedy at congressional hearings on the constitutional rights of the mentally ill:

The Department considers the deprivation of liberty without due process in violation of the above [civil rights] statute . . . is shown only if investigation reveals that the complainant has been committed in defiance of State law and with intent to take away his liberty, or he has, with similar intent, been detained after becoming eligible for release, or has been willfully subjected to brutality amounting to summary punishment.

*The Department . . . makes no surveys or investigations of State mental institutions to determine general conditions therein. It has no authority with respect to the manner in which patients*

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88. *Hernandez v. California*, 11 Cal. App. 3d 895, 90 Cal. Rptr. 205 (1970).

89. 364 F.2d at 660.

90. *Id.* at 662.

91. *Id.* at 662 n.19. Courts have been receptive to cases concerning unequal quality of care given non-psychiatric patients. *Simkins v. Cone Memorial Hosp.*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964); *Marable v. Alabama Mental Health Bd.*, 297 F. Supp. 291 (M.D. Ala. 1969).

*are admitted or in connection with the quality of care and treatment accorded them. Such matters are within the exclusive jurisdiction of the States.*<sup>92</sup>

Since that time, the federal government has shown itself increasingly willing to intervene against discrimination and to regulate in the interests of health, and this kind of concern will have to be extended to state hospital patients.

*(4) Patients themselves must be involved in the improvement of the state hospital system.*

Many mental hospitals now have some kind of patient-participatory self-government, although patients complain that the areas where they are allowed to make decisions are circumscribed and unimportant. Patients with legitimate demands for hospital improvement are often considered troublemakers, their requests are ignored, or they are penalized for their complaints. State hospitals will have to heed patients' requests for their own representatives at hospital staff and trustees meetings. In addition to the involuntary patients' major grievance of loss of freedom, they have innumerable minor grievances against the hospital as a milieu for dignified living. Much as prisoners complain of the atmosphere of bureaucracy, insensitivity, and cruelty in which their legitimate requests go unanswered, mental patients have complaints about food, living conditions, and administrative policies. The complaints are often disregarded, creating a poor atmosphere for therapy. Thus, there seems to be a clear need to provide an ombudsman in the state hospital system. The ombudsman could receive the recurring complaints of mental patients: a lack of electrical outlets in a day-room depriving patients of good reading light; a patient who wants to see his doctor about a weekend pass, but is repeatedly put off; a ward's complaint that a pay telephone is not available; continued censorship of mail in spite of an announced new policy against censorship.

Tensions caused by unrelieved deficiencies, restrictions, and impositions build up in prisons to the point of an Attica; after the explosion, the need for reform is brought to the attention of the press and the public, and finally, there may be action. However, the mental patient lives under less stressful and less circumscribed conditions, and tensions do not build up to the point of explosion. Moreover, the organizing ability and the aggressive qualities that lead to prison revolt are not

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92. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 87th Cong., 1st Sess. 401 (1961) (emphasis added).

characteristic of many state hospital patients. The mental patient is less oppressed than the prisoner, but he is also less effective in calling his plight to public attention and in achieving internal institutional reform.

(5) The care of mental patients requires so much manpower that *a more efficient use of paid nonprofessional short-time and volunteer help is needed.*

To overcome the shortage involves the recruitment of the untrained, but at the same time the interested and the concerned. The use of volunteers and short-timers has serious drawbacks. For example, untrained personnel can be a disruptive influence on mental patients. Using volunteer and short-time manpower can easily backfire because legislatures are then relieved of the pressure to provide more money for trained personnel — the goal of the right to treatment movement. Moreover, volunteers and short-timers who participate in a program for only a limited period of time require training — a drain on existing manpower and much of which goes to waste when the volunteer ceases his activity.

The advantages of securing voluntary help, however, seem to outweigh its disadvantages. Society has increasingly relegated responsibility for the individual in trouble — mental patient, geriatric patient, orphan, delinquent, prisoner — to a professional corps which maintains the individual and keeps him from interacting with society; we prefer to segregate our unfortunates. This abdication of responsibility works only when government funds provide the manpower for this kind of insulated system. Since the funds are not inexhaustible and since the competition for them is increasing, the use of volunteers is needed to maintain even the present unsatisfactory levels of providing care. As a result, to improve the system, a large-scale use of volunteers is needed. Volunteers and short-timers will provide a bridge between the institution and the community.

The volunteer or short-timer cannot be stereotyped. Many state hospitals have had experience with conscientious objectors working in lieu of military service as individual and group therapists in spite of a lack of professional background. Although the use of nonprofessionals to do professional work undermines the rationale for professional training, the fact remains that some conscientious objectors have been indispensable in helping hospitals maintain minimum treatment programs.

Who should be the volunteers? There is a natural assumption that the volunteer role is one primarily for young people. Certainly young people are appropriate candidates for a wide variety

of volunteer roles. But certain roles require a greater degree of maturity and human understanding than young people can muster, and for these roles retired people or women who have finished with child-rearing may be better qualified.<sup>93</sup>

The volunteer and the short-timer can be the eyes of the community scrutinizing what takes place behind hospital walls. They can also be the representatives of the community who import into the institutional setting some sense of a more "normal" life-style and value system.

(6) *The state hospital system must make greater use of part-time professional personnel.*

Many of psychiatry's private practitioners have jobs that pay well and surroundings that are pleasant; they work with patients who are often, although not always, motivated to seek help and are cooperative. State hospital work, on the other hand, is like prison psychiatry: it is often depressing; it presents troublesome administration problems; patients are often unmotivated; working conditions are poor. Prisons often deal with the problem by using part-time personnel. A psychiatrist who would be loath to devote his whole professional life to a state hospital population might be willing to spend one-half or three-fourths of his time in such a post. The wall that divides the state hospital system from the remainder of psychiatry will have to fall at some point, and psychiatrists as well as other highly trained personnel, such as nurses, psychologists, and social workers, will have to be given positions that allow them to alternate with other less taxing, and more financially rewarding, kinds of professional experience.

The use of part-time personnel has its pitfalls. The major problem is that some practitioners manage to work at three half-time jobs and find time for private patients on the side; if the pressure of time requires that some pursuit be sacrificed, it is the poorly paid institutional job that is all too often slighted in favor of the higher paying private patient. Another problem with part-time personnel is that they have poor communication with the hospital and are unable to participate in producing change as effectively as they might like. Nevertheless, private practitioners who now have no contact with the state hospital system are needed to upgrade that system. By working as part-time personnel, they not only bring their skills, but also, hopefully, are in contact with the training-hospital and university-affiliated personnel who also would be involved.

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93. Yarmolinsky, *The Service Society*, DAEDALUS 1263, 1274 (Fall 1968).



(7) Proper use of the mental hospital requires *stricter attention to the criteria of committability*.

The chief irregularity in our commitment procedures comes not at the time of the initial commitment, when many psychiatric patients are indeed a danger to themselves or to others and in need of involuntary commitment, but at a later stage, when the patient could be given increasing freedom, moved to a halfway facility, or released. California has recognized this problem in its mental health law which requires a redetermination of committability at ninety day intervals,<sup>94</sup> but many states continue to deprive the patient of the opportunity to demonstrate that he has recovered to the point where he no longer meets the criteria for committability.

A recent National Institute of Mental Health study of patients at St. Elizabeth's Hospital in the District of Columbia indicated that 68 per cent of the patients had no behavior problems requiring continued hospitalization.<sup>95</sup> They could not be considered dangerous to themselves or to others and could be transferred to their own homes, to foster homes, or to nursing homes, with psychiatric outpatient care available when needed. Hospital officials, generally agreeing with the diagnostic findings of the report, nevertheless said they could not find "nearly enough acceptable alternative facilities"<sup>96</sup> in the Washington area.

In addition to such surveys, a series of recent *in vivo* sociological experiments (occurring when courts ordered committed patients to be released on constitutional or statutory grounds, although the hospital staffs had testified that release was not appropriate) has demonstrated that many patients remain in hospitals long after the need for hospitalization is over. Patients released against medical advice did not fulfill the predictions of danger to themselves or to others.<sup>97</sup>

A similar experiment resulted from a threatened strike of hospital employees in New York in 1968 which led hospital authorities to return patients to their families.<sup>98</sup> A large percentage (62 per cent) of those who remained out for four weeks were still out in the community six months later. Measured by an objective scale of psycho-

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94. CAL. WELF. & INST'NS CODE § 5300 (West 1972).

95. Psychiatric News, Oct. 16, 1971, at 3, col. 4.

96. *Id.* It has been this author's experience that many patients who are sent to state hospitals could have been treated on an outpatient basis, as office patients, if they had had access to psychiatric care before their symptoms became unmanageable. On unnecessary hospitalization in the geriatric age group, see Letter from Robert Butler to the Editor, Psychiatric News, Jan. 6, 1971, at 2, col. 1.

97. Hunt & Wiley, *Operation Baxstrom After One Year*, 124 AM. J. PSYCHIAT. 974 (1968); Steadman & Halfon, *The Baxstrom Patients: Backgrounds and Outcomes*, 3 SEMINARS PSYCHIAT. 376 (1971).

98. Barrett, Kuriansky & Gurland, *Community Tenure Following Emergency Discharge*, 128 AM. J. PSYCHIAT. 958 (1972).

pathology, there was essentially no difference between the patient group who remained out for four weeks and the patient group who returned to the hospital, indicating this experience had application to a broad group of chronic patients.<sup>99</sup> A field interviewer who visited the patients with their families "was struck by the warm and accepting attitude of many of the families, even when the patients appeared to her to be obviously disturbed, and by their apparently genuine enjoyment of the patient's presence."<sup>100</sup>

[The findings] suggest additional avenues that may aid in prolonging community tenure. Perhaps giving monetary allowances to keep a patient at home, assuming genuine interest in him can be demonstrated, is a program to explore. Perhaps some families' "negative" attitude towards the patient's release, which appeared to be related to an early return, could be changed if the hospital staff knew of it and had programs to change it.<sup>101</sup>

Another alternative to total institutionalization is the day hospital, where patients can receive a complete program of psychiatric rehabilitation, but not be separated from their families at nights and on weekends. One research group has reported that the use of the day hospital offers patients an opportunity for a quicker recovery. But even therapists who had seen the greater efficacy of day care treatment preferred to commit patients for inpatient care.<sup>102</sup> Administrative pressure could be employed constructively to counteract that preference. The halfway house provides another alternative to the state mental hospital.

Stricter commitment proceedings, legal counsel for patients at commitment proceedings, constant concern over the patient's commitment, and more alternatives to commitment provide methods of decreasing the burden of the state hospital so that better care can be provided for fewer patients.

(8) The basic reform that is needed, however, is the *formulation of objective standards of care so that adequacy of treatment can be evaluated.*

The APA has always been a leader in the formulation of such standards. Recently it has supplemented its standards for adults by publishing its first official standards for psychiatric facilities serving children and adolescents.<sup>103</sup> It has proposed that all health facilities,

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99. *Id.* at 964.

100. *Id.* at 963.

101. *Id.*

102. Herz, Endicott, Spitzer & Mesnikoff, *Day Versus Inpatient Hospitalization: Controlled Study*, 127 AM. J. PSYCHIAT. 1371 (1971).

103. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES SERVING CHILDREN AND ADOLESCENTS (1972).

public and private, attempt, as much as possible, to meet the standards of practice required for accreditation by the Joint Commission on Accreditation of Hospitals ("JCAH").<sup>104</sup> However, APA standards for mental hospitals fail to provide definite guidelines for the measurement of patient care because former numerical ratios of patients to personnel have been eliminated, because many criteria are unduly vague, and because the APA has consistently recognized differing standards of care for public and private mental hospitals.

Some psychiatrists feel that not only is it an imposition to be required to formalize and fully specify treatment standards, but it is also a threat to the autonomy of the therapist. Nevertheless, private mental hospitals are accustomed to conforming their standards to those of the JCAH in order to be eligible for federal funds for their Medicare and Medicaid patients, and medicine generally is accepting the increasing scrutiny of utilization review committees.

Under these circumstances, it would seem to be in psychiatry's self-interest, through the APA, a federally sponsored commission, or the National Institute of Mental Health, to publish definitive standards by which the courts could determine, without appointing their own experts in each case, whether minimum standards of treatment are met. Objective standards for psychiatric care are overdue; they are needed for the effective use of psychiatric treatment review boards.

The eight-point program set forth above does not obviate the need for court recognition of the right to treatment or for continued court and legislative interest in the rights of the committed. Possibly, we would not be debating treatment standards now if Birnbaum had not formulated his theory and if jurists, like Bazelon and Johnson, had not seen their merits.

But a solution to the problem demands more than action by the courts to pressure the legislatures and more than mere legislative pronouncements of a right to treatment. The promulgation of standards of care and the enforcement of those standards are essential, but, more importantly, there must be an acceptance of responsibility for the plight of the state hospital by others, as well as by judges, legislators, and hospital administrators. Birnbaum's attack on the problem, no matter how well considered and humane, will not be successful without the support of psychiatry's private practitioners, its university-affiliated and training-hospital-affiliated programs, the young, the volunteers — in short, without help from society as a whole.

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104. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, STANDARDS FOR ACCREDITATION OF HOSPITALS (1969).